MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-6

01235

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 201 - 10th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rosella Beall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: William Gray Beall
6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1864

8. AGE:

Years	Months	Days	If less than one day
83	1	13	...hrs. ...min.

8. Birthplace: Laurel, Anne Arundel, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —
FATHER 12. Name: Andrew Frothingham
13. Birthplace: Md
MOTHER 14. Maiden name: Martha Merson
15. Birthplace: Md.
16. Informant: Wm. G. Beall
Address 201-10th St. Laurel Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-7-1947 (month) (day) (year)
Cemetery or crematory: Ivy Hill
Location: Laurel Maryland
18. Funeral director: DeWitt Donaldson
Address: Laurel Md.
19. April 7 19 47 M. Beall Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 19 47, at 4 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
4 19 44, to 4 4 19 47
and that I last saw h[illegible] alive on 4 — 4 — 19 47

Immediate cause of death	DURATION
Hypocardial Failure	3 days
Due to: Arteriosclerosis	10 yrs
Due to: Senility	10 yrs
Other conditions: D.M. Phelps —	Late

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. M. Mason M.D.
M. D. or other
Address Laurel Md. Date signed 4-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01236

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Dillon Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Years
Hospital, Institution, or street address where death occurred: --------
How long in hospital or institution? --------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Dillon Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5214 - G Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EDWIN JACKSON BEAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 31, 1869

8. AGE: Years	Months	Days	If less than one day
77	7	29	hrs. min.

9. Birthplace: Garland, West Virginia (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Jessie Bean
13. Birthplace: Garland, West Virginia

MOTHER
14. Maiden name: Nancy Jane Reed
15. Birthplace: West Virginia

16. Informant: Benjamin F. Bean
Address: Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Md. (Prince Geo. Co.)

18. Funeral director: Martin W. Hysong Co.
Address: 1300-N St. N.W., Washington, D.C.

19. April 30 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29, 1947 19..... at 5:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1947 to April 29 1947 and that I last saw him alive on April 29 1947.

	DURATION
Immediate cause of death: Cerebral embolism	days
Due to: arteriosclerotic heart disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arved Achen MD
M. D. or other
Address: 2713 Wisconsin Ave. Date signed: April 30-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

01237

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, Institution, or street address where death occurred:

8000 Walker Mill Drive

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8000 Walker Mill Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Grace Cleo Bean

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James B. Bean

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): April 27 1887

8. AGE: Years: 59 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Lute Amoss

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Belle Collins

MOTHER — 15. Birthplace: Virginia

16. Informant: James B. Bean

Address: 8000 Walker Mill Drive S.E.

17. April 8, 1947 (Burial, cremation, or removal. Which?) Date thereof: Burial (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington D.C.

18. Funeral director: J. Wilburn Lees Sons Co.

Address: 300 - 4th St. N. W.

19. 4/5/47 (Date rec'd by registrar) 19 Thos E Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 19 47 at 10:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Deputy medical Examiner James B. Bond M. D. or other

Address: 7 Forestville Md. Date signed: 4-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01238

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Prince Georges
City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Permanent
Hospital, institution, or street address where death occurred:
near Calvert Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 616 - Green Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Henry Beck Jr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Mary E. Beck
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Oct 1, 1881

8. AGE: Years: 65 | Months: 6 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Columbia Pa
(Town, county, and state)

10. Usual occupation: Guide

11. Industry or business: Hunting and Fishing

FATHER
12. Name: William Henry Beck
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Elizabeth Brookes
15. Birthplace: Pennsylvania

16. Informant: William A. Beck
Address: 463 Fordham Rd. College Park

17. (Burial, cremation, or removal. Which?) transportation
Date thereof: April 19, 1947 (month) (day) (year)
Cemetery or crematory: Angel Hill Cemetery
Location: Havre de Grace Md

18. Funeral director: E. Gascha sons
Address: Hyattsville Md

19. April 19, 1947 (Date received by registrar)
Mrs. Jan. Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 1947, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to: Drowning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 4-19-47
Where did injury occur: College Park (City or town) P.G. (County) Md (State)
Injured at home, farm, industry, public place (where?): Pool in front of dump
Means of injury: Fell in pool Injured at work? No

Deputy medical Examiner

23. SIGNATURE: [signature] M. D. or other
Address: Hyattsville Md Date signed: 4-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61239

136

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 1 day

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 month, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 W. Clifton Terrace, N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOSEPH H. BECKER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian Becker

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): June 27, 1875

8. AGE: Years	Months	Days	If less than one day
71	10	3	....hrs. ....min.

9. Birthplace: Indianapolis, Indiana
(Town, county, and state)

10. Usual occupation: Projectionist

11. Industry or business: Movie

FATHER
12. Name: George W. Becker
13. Birthplace: Pittsburg, Pennsylvania

MOTHER
14. Maiden name: Emma Harcum
15. Birthplace: Indianapolis, Indiana

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr 30 1947 (month) (day) (year)

Cemetery or crematory:
Location: to Washington, D. C.

18. Funeral director: S. H. Hines Co.
Address: 2901 14th St NW Wash DC

19. Apr. 30, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 30 1947, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 28 1947, to APRIL 30 1947

and that I last saw him alive on APRIL 30 1947

Immediate cause of death: PULMONARY TUBERCULOSIS — DURATION: 5 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel L. O. Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 4.30.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

C1240

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4400 Silver Hill Rd. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Mildred Anne Benecne

3.(b) Social Security Number: 121-09-3166

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ...years

7. Birth date of deceased (mo., day, yr.): January 12, 1915

8. AGE:

Years	Months	Days	If less than one day
32	2	20	...hrs. ...min.

9. Birthplace: Lock Port, New York
(Town, county, and state)

10. Usual occupation: Secretary

11. Industry or business: Dept. of Agriculture

FATHER
12. Name: Hermann August Benecne
13. Birthplace: New York.

MOTHER
14. Maiden name: Clara Mae Platt.
15. Birthplace: New York.

16. Informant: Hospital Records
Address: Riverdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4 1947 (month) (day) (year)
Cemetery or crematory: 1766 - Pierce Mill
Location: Baltimore, Md.

18. Funeral director: Joseph Gawler's Sons
Address: 1756 Penna. Ave. N.W. Washington, D.C.

19. April 4 1947 (Date rec'd by registrar) Jules Levey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1947 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946 to 4 April 1947 and that I last saw h... alive on 3 April 1947

	DURATION
Immediate cause of death: Circulatory Failure	1 mo.
Due to: Chronic Rheumatic Heart disease	25 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Sidney W. Levey M.D.
M. D. or other
Address: 1503 Good Hope Rd. S.E. Wash. D.C. Date signed: 4-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01241

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one yr., 5 mos., 29 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 5 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 645 Morton St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BIVENS, BEATRICE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: George Bivens
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): October 5, 1882

8. AGE: Years	Months	Days	If less than one day
64 64	6	18	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: Frank Smith
13. Birthplace: Rappahanack, Virginia

MOTHER
14. Maiden name: Mary Williams
15. Birthplace: Washington, D. C.

16. Informant: Deceased
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 4-24-47 (month) (day) (year)
Cemetery or crematory:
Location: to Washington D.C.
18. Funeral director: Malvan & Schey Inc.
Address: 424 R. St. N.W.

19. Apr 23, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23, 1947, at 5:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/24 1945 to 4/23 1947
and that I last saw h... alive on 4/23 1947

Immediate cause of death	DURATION
pulmonary tuberculosis	22 mos
Due to	
Due to	
Other conditions: diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 4/23/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

01242

Reg. Dist. No. 2 4 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Suitland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Suitland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4602 Chelsea ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hazelle E Blake

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 18, 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
57				

9. Birthplace: Iowa (Town, county, and state)

10. Usual occupation: Clerk, U. S. Govt

11. Industry or business: Social Security

FATHER 12. Name: Sebastian J Streeter

13. Birthplace: Iowa

MOTHER 14. Maiden name: Rhuey Duncan

15. Birthplace: Iowa

16. Informant: Bonnie Blake Anderson

Address: 4602 Chelsea ave, Suitland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 15 1947 (month) (day) (year)

Cemetery or crematory

Location: Mount S. Dakota

18. Funeral director: Robert A Mattingly

Address: 131-(1a St S.E. Washington DC

19. April 15 1947 (Date rec'd by registrar) Thos S Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1947 at 11 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13 1946 to April 13 1947 and that I last saw h.. alive on April 13 1947

Immediate cause of death	DURATION
Exfoliation	Six months
Melanotic Carcinoma	
Lung - Primary Source	
Due to: Unknown	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

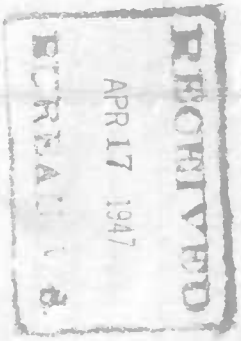
Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Joseph Arthur Jeffries M D M. D. or other

Address: 1861 G St NW Washington DC Date signed: 4-14-47

Dr Boyd The Coroner Notified
and approved
L. A. J.r. 4-14-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01243

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 hrs.
Hospital, Institution, or street address where death occurred:
Pr. Geo. General Hosp.
How long in hospital or institution? 20 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. George
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5901 Cleveland ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bowie, Mrs. Sadie

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife: Mr. Bruce Bowie
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10-10-1880

8. AGE:

Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: Winchester, Va.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Andrew Kerfoot
13. Birthplace: Va.

MOTHER
14. Maiden name: Elizabeth Copenhaver
15. Birthplace: Va.

16. Informant:
Address:

17. (Burial, cremation, or removal, Which?) Burial Date thereof 4-10-47 (month) (day) (year)
Cemetery or crematory: Glenwood
Location: Washington D.C.
18. Funeral director: H. P. Chambers Co.
Address: 5801 Cleveland Ave Riverdale Md.
19. 4/8 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-8 19 47, at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 19 47, to April 8th 19 47
and that I last saw her alive on April 8th 19 47

Immediate cause of death	DURATION
Diabetic coma	24 hours
Due to: Diabetes mellitus	several years
Due to:	
Other conditions: Diabetic gangrene of Right toes of the right foot with toxaemia	1 year

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Louis K. Hirsch M.D. M. D. or other
Address: College City, Va. Date signed: 4-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01244

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH
County: Pro Geo Hospital
City or town: Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hrs 25 minutes
Hospital, institution, or street address where death occurred:
Pro Geo Hospt. 33 3/4 hrs
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Mt Rainier Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4200 Kaywood drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Ste Neane Bradley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Robert F. Bradley.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 7, 1917.

8. AGE: Years	Months	Days	If less than one day
29.	8.	18.	..... hrs. ..... min.

9. Birthplace: Washington Dc.
(Town, county, and state)
10. Usual occupation: Clerk - interviewer
11. Industry or business: U.S. Government

FATHER
12. Name: Curtis C. Ste Neane
13. Birthplace: Washington Dc.

MOTHER
14. Maiden name: Florence Gaseon
15. Birthplace: Washington Dc.

16. Informant: R. F. Bradley
Address: 4200 Kaywood Drive Mt Rainier Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 28. 1947 (month) (day) (year)
Cemetery or crematory: Lost Lincoln Cemetery
Location: Colmar Manor Md

18. Funeral director: F. Gaschè sons
Address: Hyattsville Md.

19. 4/28 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10. 1940 to April 25 1947
and that I last saw h.. alive on April 25 1947

Immediate cause of death	DURATION
Hyperpyrexia	
Due to following operation	
for Appendectomy.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C Watz 4 MD M. D. or other
Address: Hyattsville Md Date signed 4-25-47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01245

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Prince Geo

County [redacted]

City or town Upper marlboro Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Geo

City or town Upper marlboro md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah A. Brooks

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	Negro	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 15 1868

8. AGE:

Years	Months	Days	If less than one day
78			..... hrs. ..... min.

9. Birthplace Prince Geo Co (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER

12. Name Joseph Green

13. Birthplace Prince Geo Co

MOTHER

14. Maiden name Emma

15. Birthplace Prince Geo Co md

18. Informant William Brooks Son

Address Upper marlboro md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-3-47 (month) (day) (year)

Cemetery or crematory Gibbons Cemetry

Location Rural Brandywine Md

18. Funeral director Hurtt & Rixon

Address Wedon Md

19. May 47 (Date rec'd by registrar) Mrs. A. E. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947, at 12:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 1947, to Apr 30 1947 and that I last saw h.er alive on April 29 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 wks
Due to Nephritis	10 yrs
Due to Arteriosclerosis	20 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. —

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James E. Spencer M. D. or other

Address Upper Marlboro, Md Date signed 9-30-47

01246

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 603 Kennilworth Terrace, N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: MAMIE E. BROWN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: - - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20, 1929

8. AGE: Years	Months	Days	If less than one day
17	10	10	hrs. min.

9. Birthplace: Marsella Co., South Carolina
(Town, county, and state)

10. Usual occupation: Dish Washer

11. Industry or business: - -

FATHER — 12. Name: William Brown

FATHER — 13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Mary Byrd

MOTHER — 15. Birthplace: Marsella Co., South Carolina

16. Informant: Deceased

Address:

17. Burial, cremation, or removal: Removal (Burial, cremation, or removal. Which?) Date thereof: 5/1/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: A. S. Pope

Address: 516 - 15th St SE

19. Apr. 30, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30th 1947, at 5-25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29th 1947 to April 30th 1947 and that I last saw her alive on April 30th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Apr. 30, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 01234 2334

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Pr. Geo
City or town Cheverly
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) 12 hrs
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr Geo Co
City or town (If outside city or town limits, write RURAL NEAR and give town) Ward No. Cheverly
Street No. 6723 - New Hampshire
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Samuel Braun

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hrs. min.

9. Birthplace Pr Geo Co. (Town, county and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name James F Braun
13. Birthplace Md

MOTHER
14. Maiden name Carolyn Jones
15. Birthplace Md

16. Informant Grace Braun
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-8-47 (month) (day) (year)
Cemetery or crematory
Location Wash DC
18. Funeral director W R Huntemann
Address 5732 Ga Ave NW
19. 4/8 19 47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 19 47, at 1:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-17-47 19 , to 4-8- 19 47, and that I last saw h 1 M alive on 4-7-47 19

Immediate cause of death	Uremia	DURATION 3 days
Due to	Chronic Nephritis	3 yrs
Due to		
Other conditions		

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John P. Cain M.D.
M. D. or other
Address Hyattsville Md Date signed 4-8-47

01247

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs
Hospital, Institution, or street address where death occurred: 5360 Oxon Hill Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5360 Oxon Hill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Peter Mc. Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife Nellie Brown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE:	Years	Months	Days	If less than one day
	84			..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Jem Brown
13. Birthplace Maryland

MOTHER
14. Maiden name Smith
15. Birthplace Unknown

16. Informant Blanche Smith
Address 5360 Oxon Hill Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-23-47 (month) (day) (year)
Cemetery or crematory Oxon Hill Md.
Location Oxon Hill Md.

18. Funeral director John T. Rhines & Co.
Address 901-3rd St. S.W.

19. 4/21- 1947 (Date rec'd by registrar) Thos S. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947, at 3 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Deputy Medical Examiner
M. D. or other
Address Forestville Date signed 4-20-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

MARGIN RESERVED FOR BINDING

VS A15

01249

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-8)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town HYATTSVILLE (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MD County PRINCE GEORGE
City or town HYATTSVILLE (If outside city or town limits, write RURAL and give nearest town)
Street No. 6412 Elliot Pl. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JULIUS BUCHMAN
3.(b) Social Security Number

4. Sex: MALE
5. Color or race: WHITE
6.(a) Single, married, widowed, or divorced: MARRIED
6.(b) Name of husband or wife: RAY
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 1900
8. AGE: Years 47; Months; Days; If less than one day ... hrs. ... min.
9. Birthplace RUSSIA (Town, county, and state)
10. Usual occupation CUTTER
11. Industry or business TEXTILES
FATHER
12. Name Joseph Buchman
13. Birthplace RUSSIA
MOTHER
14. Maiden name Unknown
15. Birthplace RUSSIA
16. Informant MORRIS JEWLER
Address 5022 N. CAPITOL ST
17. Burial (Burial, ~~cremation, or removal~~, Which?) Date thereof April 15, 1947 (month) (day) (year)
Cemetery or crematory Wellwood Cemetery, L.I. N.Y.
Location
18. Funeral director B. Danzansky & Son
Address 3501 14th St NW Wash. D.C.
19. 4/14 1947 (Date rec'd by registrar) May E. Hines Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 April 1947 at 2:15 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 April 1947 to 14 April 1947 and that I last saw him alive on 13 April 1947

Immediate cause of death	DURATION
Congestive Heart Failure	1 year
Due to Auricular Fibrillation	3 mons
Due to Rheumatic Heart Disease	7 years
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Samuel J. Sugar M.D. (M. D. or other)
Address 4300 Kaywood Dr. Mt Rainier Md. Date signed 14 April 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01250

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 14 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 month, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1324 V. Street, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: William Carter Jr.

3. (b) Social Security Number: 578-18-3378

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: - -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25, 1910

8. AGE: Years	Months	Days	If less than one day
36	3	21	hrs. min.

9. Birthplace: Louisa, Virginia (Town, county, and state)
10. Usual occupation: Moving Man
11. Industry or business: - -

FATHER
12. Name: Nelson Carter
13. Birthplace: ?, Virginia

MOTHER
14. Maiden name: Alice Smith
15. Birthplace: Louisa, Virginia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr. 15 1947 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.

18. Funeral director: Allen & Morrow Inc.
Address: 1326 Vee St. N. W.

19. Apr 15 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15, 1947 at 2:00 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/5 1947 to 4/15 1947
and that I last saw h. alive on 4/15 1947

	DURATION
Immediate cause of death: pulmonary Tuberculosis	7 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 4/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

01253

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Woodyard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
On Claggett Sweeney's Farm
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maine County:
City or town: Portland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 16- Wood Road
(If rural, give LOCATION)
2.(a) If veteran, name war: World War # II ✓

3.(a) FULL NAME
John Moshier Chapin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Zemp Chapin
6.(c) If alive, give age: Unk years

7. Birth date of deceased (mo., day, yr.): June 21, 1919

8. AGE: Years	Months	Days	If less than one day
27	9	18	...hrs. ...min.

9. Birthplace: Newburgh, N. Y. (Town, county, and state)
10. Usual occupation: Major
11. Industry or business: U.S. Army
12. FATHER — Name: Willis Chapin
13. FATHER — Birthplace: Mich.
14. MOTHER — Maiden name: Fannie Guilford
15. MOTHER — Birthplace: Yonker, N. Y.
16. Informant: U.S. Army
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/10/47 (month) (day) (year)
Cemetery or crematory: Parkland
Location: [illegible]
18. Funeral director: [illegible]
Address: 317-11 St. [illegible]

19. 4/10/47 (Date rec'd by registrar) Carrie J. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 April 19 47 at 1106A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death: Hemorrhage, shock — DURATION:
Due to: Multiple lacerating, crushing injuries to body
Due to:
Other conditions: Body was reduced to fragments
(Includo pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 7 April 47
Where did injury occur? Woodyard, Prince Georges, Md. (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?): on a farm
Means of injury: Plane crash Injured at work? Yes

23. SIGNATURE: [illegible] Deputy medical Examiner M. D. or other
Address: Hyattsville Md. Date signed: 4-8-47

Especially important: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-a)

CERTIFICATE OF DEATH

01254

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Hyattsville Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Pro Geo Co
City or town: Hyattsville Md (If outside city or town limits, write RURAL and give nearest town)
Street No. 5314 - 42 ave (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mae Howard Cissel
3. (b) Social Security Number

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Frank M Cissel
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March 15, 1870
8. AGE: Years 77 Months Days If less than one day ... hrs. ... min.
9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Navy Department
FATHER 12. Name: Henry O Howard
13. Birthplace: Washington D.C.
MOTHER 14. Maiden name: Roberta Dyer
15. Birthplace: Washington D.C.
16. Informant: Mr. Wm. E. Howard
Address: Hyattsville Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof: apr 9, 1947 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Washington D.C.
18. Funeral director: T Gasch's Sons
Address: Hyattsville Md
19. apr 9 1947 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: apr 7 1947, at 1:25 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to ap 7 1947
and that I last saw h... alive on 4-6 1947

	DURATION
Immediate cause of death: Toxemia	
Carcinoma R. Kidney	4 mo
Due to	
Due to: More or less continuous bleeding from Mch 1/47	
Other conditions: X ray demonstrated filling defect Mch 1-47 (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: 4105 Jefferson Hyattsville Date signed 4/7/47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B 01255

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 711 - 24th St., N. E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CLARKE, ETHEL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Charles Clarke

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): September 6, 1922

8. AGE: Years	Months	Days	If less than one day
24	7	6	..... hrs. ..... min.

9. Birthplace: Waynesboro, Virginia (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER

12. Name: Emitt Shepherd

13. Birthplace: Waynesboro, Virginia

MOTHER

14. Maiden name: Grace Page

15. Birthplace: Rockfish, Virginia

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-13-47 (month) (day) (year)

To Wash D.C.

Cemetery or crematory:

Location:

18. Funeral director: W Ernest Jarvis Co

Address: 1432 You St NW

19. Apr. 12, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 19 47 at 4 35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/26 19 47, to 4/12 19 47

and that I last saw h. alive on 4/12 19 47

Immediate cause of death	DURATION
pulm. Tuberculosis	11 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane MD M. D. or other

Address: Glen Dale, Md., Date signed: Apr. 12, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01256

Reg. Dist. No. 745

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 - 8th Street S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Ernest Lawrence Clarke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Annie Clarke

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): July 19, 1875

8. AGE: Years: 71 Months: 9 Days: 14 If less than one day: ..... hrs. ..... min.

9. Birthplace: Bowie, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER

12. Name: Crittenden C. Clarke

13. Birthplace: Bowie, Maryland

MOTHER

14. Maiden name: Sarah Wells

15. Birthplace: Bowie, Maryland

16. Informant: Bernard Clarke

Address: Bowie, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-6-47 (month) (day) (year)

Cemetery or crematory: White Marsh

Location: R.F.D. Lee Co.

18. Funeral director: Martin Gladden J. Sons

Address: Bowie

19. April 5 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1947 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Intra Cranial hemorrhage	
Due to Fracture of skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 4-2-47

Where did injury occur? Bowie (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where)? at home

Means of injury: fall down stairs Injured at work?

Deputy Medical Examiner

23. SIGNATURE: James J. Ford M. D. or other

Address: Forestville Md. Date signed 4-5-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 01257 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Prince George's

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:

5300 - 43rd Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5300 - 43rd Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sister Clara Coffey S. N. D. de Namur

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1, 1885

8. AGE: Years 61 | Months | Days | If less than one day hrs. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual occupation Teacher

11. Industry or business School

FATHER 12. Name Michael Coffey

13. Birthplace Ireland

MOTHER 14. Maiden name Margaret Croffey

15. Birthplace Ireland

16. Informant Sister Gertrude Mary

Address 5300 - 43rd Ave., Hyattsville Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-21-47 (month) (day) (year)

Cemetery or crematory Trinity Cemetary

Location Winchester Md

18. Funeral director Thomas P. Hanlon

Address 641 L St N. E. Wash D.C.

19. April 21 19 47 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 19 47, at 6 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19, to 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death acute congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

23. SIGNATURE James F. Ford M. D., another

Address Hyattsville md Date signed 4-20-47

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-6)

CERTIFICATE OF DEATH

01258

FILM No. G 1[illegible] APR 17 1947

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: PRINCE GEORGES

City or town: HYATTSVILLE (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 YEARS

Hospital, Institution, or street address where death occurred: 5805 QUEENS CHAPEL Rd.

How long in hospital or institution? 7 YEARS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: DISTRICT OF COL. County:

City or town: WASHINGTON. (If outside city or town limits, write RURAL and give nearest town)

Street No. 3209 WALNUT ST. N.E. (If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3. (a) FULL NAME: ANNIE COFFMAN.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Widow.

8.(b) Name of husband or wife: GILLMAN COFFMAN

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): OCTOBER 24, 1856

8. AGE: Years	Months	Days	If less than one day
90 19111	5	15	..... hrs. ..... min.

9. Birthplace: FAIRFAX, VIRGINIA (Town, county, and state)

10. Usual occupation: HOUSEWIFE.

11. Industry or business: NONE

FATHER 12. Name: John MARKS

FATHER 13. Birthplace: FAIR FAX, VIRGINIA.

MOTHER 14. Maiden name: MARGARET BROOKS

MOTHER 15. Birthplace: FAIRFAX, VIRGINIA

16. Informant: T.B. Coffman

Address: 5019 - 6th St Apt. Virginia

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof: April 10th 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Glenwood Cemetery.

Location: Washington D. C.

18. Funeral director: W. W. Chambers Co.

Address: 1400 Chapin St. N.W. Wash. D.C.

19. April 8 19 47 (Date rec'd by registrar) Mrs. Jane Devereux Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 19 47, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 46 to April 8 19 47 and that I last saw h... alive on April 6 19 47

Immediate cause of death	DURATION
Carcinoma of Bladder	7 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thomas F Collins MD M. D. or other

Address: 322 - H ST NE Date signed: 4-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9 (3rd)

CERTIFICATE OF DEATH

★ B 01259

Reg. Dist. No. 2-30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
Sacred Heart Home
How long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: WASHINGTON
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1523 - 22nd. St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: NELLIE COLCLAZIER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 26, 1862 ✓

8. AGE: Years: 84 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: WASHINGTON D. C.
(Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business:

FATHER
12. Name: DANIEL COLCLAZIER
13. Birthplace: WASHINGTON, D.C.

MOTHER
14. Maiden name: MARTHA N. CRAWFORD
15. Birthplace: ALEXANDRIA, VA.

16. Informant: SACRED HEART HOME RECORDS
Address: Hyattsville Md

17. Burial, cremation, or removal. Which?: Removal Date thereof: Apr. 2, 1947 (month) (day) (year)

Cemetery or crematory:
Location: Washington D.C.

18. Funeral director: Spencer Collins
Address: 3821 - 14th. St. NW. Wash. D.C.

19. April 2 1947 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1938 to April 2 1947 and that I last saw him alive on April 2, 1947

Immediate cause of death	DURATION
Ac. myocardial failure	immed.
Due to: Shock from recto-sigmoid prolapse.	
Due to: old age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank R. Lea M.D.
M. D. or other

Address: 4100 - 22nd St NE Date signed: 4/2/47.

1-35

01260

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 2-5

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 min
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 30 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Suitland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4722 Huron Avenue, S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Baby Boy Cooper

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 4-11-47

8. AGE: Years | Months | Days | If less than one day: ____ hrs. 30 min.

9. Birthplace: Riverdale, Prince Georges Co., Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER
12. Name: Lindsay H. Cooper
13. Birthplace: Virginia

MOTHER
14. Maiden name: Thelma Marie Wynn
15. Birthplace: Maryland

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 14 1947 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Bladensburg Md

18. Funeral director: L. Gaeta's Sons
Address: Hyattsville Md.

19. April 14 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-11 1947 at 1 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-11- 1947 to 4-11- 1947 and that I last saw him alive on 4-11- 1947

Immediate cause of death: Asphyxia Neonatorum — DURATION: 15-30 Min

Due to: ____

Due to: ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.: ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Clarence L. Dundy M.D.
M. D. or other

Address: 1503 Good Hope Rd. D.C. Date signed: 4-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

01261

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pr Geo Co.
City or town: Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr Geo Co
City or town: 4717 Rittenhouse st
(If outside city or town limits write RURAL and give nearest town)
Street No.: Riverdale Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Blanche K. Crown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John W. Crown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 28. 1881

8. AGE: Years: 65 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Rockville Md (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: samuel Hagnet
13. Birthplace: Canada

MOTHER
14. Maiden name: Ellie Emerson
15. Birthplace: Pa

16. Informant: Josephine Arrowsmith
Address: 6112-39 place Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 28, 1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md.

18. Funeral director: J Gosche sons
Address: Hyattsville Md.

19. April 27 1947 (Date rec'd by registrar) James Seavey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1947, at 10.40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1947 to Apr 24 1947 and that I last saw ... alive on April 25 1947

Immediate cause of death	DURATION
Carcinoma of colon	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Jum and Hemp
Address: Hyattsville Md. M. D. or C. Date signed: 4/27/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-C)

CERTIFICATE OF DEATH

NV 01262

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour

Hospital, Institution, or street address where death occurred:

Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Oxon Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6721 Bock Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Donald Allen Dawson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 4, 1937

8. AGE: Years 9 | Months | Days | If less than one day hrs. min.

9. Birthplace Washington DC.

(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Noble E. Dawson

13. Birthplace Meridian Miss

MOTHER 14. Maiden name Ida Schavitts

15. Birthplace Ohio

16. Informant Noble E. Dawson

Address 6721 Bock Rd Accokeek Md

17. (Burial, cremation, or removal. Which?) Removal Date thereof April 21, 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland, Md.

18. Funeral director W. H. Chambers Co.

Address 517-11th St. S.E.

19. (Date rec'd by registrar) April 21, 1947 Registrar Amanda Downey

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1947, at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to ..., 19...

and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Fracture of skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 4-20-47

Where did injury occur? Allentown P.S. (City or town) (County) Md. (State)

Injured at home, farm, industry, public place (where?) Allentown Rd.

Means of injury bicycle struck injured at work? auto

Report medical Examiner

23. SIGNATURE ... M. D. or other

Address Forestville Md. Date signed 4-21-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-a)

CERTIFICATE OF DEATH

01263

MV Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, institution, or street address where death occurred: Melrose Crossing

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Geo Co.

City or town: Lakeland Park, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. 108-54 Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ralph Robert Hofflemyer

3.(b) Social Security Number 578-12-7795

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lillian Hofflemyer

6.(c) If widow, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Dec 20 - 1903

8. AGE:

Years	Months	Days	If less than one day
43	3	29	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Interior Decorator

11. Industry or business

FATHER — 12. Name: Ashby Hofflemyer

13. Birthplace: Va

MOTHER — 14. Maiden name: Elizabeth Ruffler

15. Birthplace: Va

16. Informant: Lillian Hofflemyer (wife)

Address: Takoma Park, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr 19, 1947 (month) (day) (year)

Cemetery or crematory: Hysong Funeral Co

Location: 1300 Nat. Ave. Washington D.C.

18. Funeral director: J Gaeke Sons

Address: Hyattsville Md.

19. April 19 1947 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1947 at 1140 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage and shock	
Due to: Multiple Crushing injuries to the entire body	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 4-19-47

Where did injury occur? Hyattsville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) R.R. Crossing

Means of injury: Passenger in Car struck by train

23. SIGNATURE: [signature] M. D. or other

Address: Hyattsville Md. Date signed 4-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B1264

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Five (5) years.
Hospital, institution, or street address where death occurred:
Home — 6110 44'th Avenue,
How long in hospital or institution? At Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6110 44'th Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Florence Mary DOWNING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Oscar Ernest Downing
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): January 8, 1877

8. AGE:

Years	Months	Days	If less than one day
70	3	2	___ hrs. ___ min.

9. Birthplace: London, England
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: James Pettengill
13. Birthplace: London, England

MOTHER
14. Maiden name: Mary Eldridge
15. Birthplace: London, England

16. Informant: Husband (Oscar Ernest Downing)
Address: 6110 44'th Avenue, Riverdale, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof April 14, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md

18. Funeral director: E. Gusti's Sons
Address: Hyattsville Md.

19. April 11 1947 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 1947, at 11:03 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1946, to April 10, 1947
and that I last saw her alive on April 10, 1947

Immediate cause of death	DURATION
Cardiac Failure	1 hr.
c Acute Pulmonary Edeme	
Due to: Hypertension superimposed on	30 yrs.
Due to: Rheumatic Heart Disease	35 yrs.
Other conditions: Erythema Nodosum ?	(yr.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Walcott W. Gibson, M.D.
M. D. or other
Address: 4404 Queensbury Rd. Riverdale, Md. Date signed: 4-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

01265

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Geo.
City or town: Randolph Village Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Randolph Village
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: FRANK R. DRAKE

3.(b) Social Security Number: 577-07-4373

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Lennie M. Drake
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 28 1892

8. AGE: Years	Months	Days	If less than one day
54			..... hrs. ..... min.

9. Birthplace: St Louis Mo.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Self

MOTHER FATHER
12. Name: J. D. Drake
13. Birthplace: St Louis Mo.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Lennie Drake
Address: Randolph Village Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 4-18-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.

18. Funeral director: W. W. Chambers Co
Address: 517 11th St S.E.

19. April 15 1947 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 April 1947, at 7.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to 15 April 1947
and that I last saw him alive on 14 April 1947

Immediate cause of death	DURATION
Hemorrhage, infarctions and thrombosis of the lungs.	2 minutes
Due to: Post operative - gall bladder removal 3 April 1947	
Due to:	
Other conditions: Cholecystitis and Cholelithiasis	Several years

(Include pregnancy within 3 months of death)

Major findings of operations: Cholecystitis and cholelithiasis gangrene gall bladder wall. Date of op. 3 April 47
Autopsy results: Not performed.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James B Mattingly M.D. M. D. or other
Address: 2201 R Ave N.E. Wash. D.C. Date signed 15 Apr 47

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Permission to sign certificate was obtained from coroner James E.Boyd M.D. It was explained that patient dropped dead following recent discharge from Doctor's Hospital where he had gall bladder removed 3 April 1947. Yesterday (14 April, 1947) he called to advise that he had a " stitch " in right side with some shortness of breath. It was relieved with a sedative. Later in the day he passed some blood clots. Pulmonary embolism was suspected and deceased was ordered to bed rest. While eating breakfast this morning he was seized with agonizing pain in chest, blindness, shortness of breath. Deceased had typical cyanosis of massive pulmonary infarction. Dead on arrival.

15 april 47

Thomas Dattingly M. D.

-Evidence for addition of "usual residence of deceased" shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

01251

FILM No. G 11 JUN 13 1947 **CERTIFICATE OF DEATH**

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Geo.
City or town: Laurel Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 162 Lafayette Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Howard~~ Prince Georges
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D. #1 Lafayette Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Warren Lawrence Dunkart — **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 16 - 1947

8. AGE: Years | Months | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Riverdale Hospital (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Warren Dunkart
13. Birthplace: Howard Co. Md.

MOTHER — 14. Maiden name: Rose May Fisher
15. Birthplace: Pennsylvania

16. Informant: Grace Fisher
Address: Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30 1947 (month) (day) (year)
Cemetery or crematory: Emanuel Church
Location: Scaggsville Md

18. Funeral director: W. H. White Co. Jr.
Address: Laurel Md

19. 4-30 1947 (Date rec'd by registrar) Cora E. Wacaster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-28 1947 at 10½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-15 1947 to 4/28 1947 and that I last saw h[illegible] alive on 4/25 1947

Immediate cause of death	DURATION
(a) Pulmonary Tuberculosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. or other
Address: Laurel Md Date signed: 7/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

01266

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 362 days

Hospital, institution, or street address where death occurred: Prince George's General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 3502 Quesada Street N.W. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Grace Clementine Farrow

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 6, 1869

8. AGE: Years	Months	Days	If less than one day
78		17	hrs. min.

9. Birthplace: Watertown, New York (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Census Bureau

FATHER — 12. Name: Charles F. Keefer

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Emma E. Beall

MOTHER — 15. Birthplace: Watertown, New York

16. Informant: Mrs. Grace Eccard

Address: 3502 Quesada Street N.W. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26 1947 (month) (day) (year)

Cemetery or crematory: Arlington Nat'l Cem.

Location: Arlington, Virginia

18. Funeral director: S. H. Finch Co.

Address: 2901-14th St. N.W. Wash. D.C.

19. April 23 1947 (Date rec'd by registrar) James Sever (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 19 47 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Congestive heart failure	
Due to: Myocardosis	
Due to:	
Other conditions: Ununited fracture of right femur	

(Include pregnancy within 3 months of death)

Major findings of operations: Amputation of right leg at mid-thigh Date of op. 3-11-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 4-26-46

Where did injury occur? Suitland (City or town) P. G. (County) Maryland (State)

Injured at home, farm, industry, public place (where?): street in Suitland

Means of injury: slipped fell on pavement Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Forestville, Md. Date signed 4-23-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

01267

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day.

Hospital, institution, or street address where death occurred:

Eugene L. Sand memorial

How long in hospital or institution? 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Berwyn

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Berwyn Trailer Camp.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Eva Faul.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed.

6.(b) Name of husband or wife: O.M.a Christian Faul

Deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 3. 1887.

8. AGE: Years	Months	Days	If less than one day
59. 1887	7	21	..... hrs. ..... min.

9. Birthplace: Wall Lake Iowa

(Town, county, and state)

10. Usual occupation: House Wife.

11. Industry or business:

FATHER — 12. Name: Moses Jackson Cooley

13. Birthplace: Illinois

MOTHER — 14. Maiden name: Catherine Overstreet

15. Birthplace: Illinois

16. Informant: Robert M. Faul Son.

Address: Berwyn Trailer Camp.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-25-47 (month) (day) (year)

Cemetery or crematory: Wall Lake

Location: Iowa

18. Funeral director: W W Chambers Co

Address: Riverdale - Md

19. April 25 (Date rec'd by registrar) 1947 James Sevey (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24, 1947 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24, 1947 to April 24, 1947

and that I last saw h[illegible] alive on April 24, 1947

Immediate cause of death	DURATION
Heart Failure with	6 hours
Cardiac Decompensation	
Due to Acute Coronary H.T.	1 day
Due to Hypertensive Heart Disease	20± yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Walter W Gibson, MD (M. D. or other)

Address: Riverdale Md. Date signed: April 24, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 01268

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bowie (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: Transient
Hospital, institution, or street address where death occurred: Bowie Race Track Butcher Shop
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Rhode Island County:
City or town: Providence (If outside city or town limits, write RURAL and give nearest town)
Street No.: 41 Bradford Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Florindo Gabelleri
3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name ~~of husband~~ or wife: Catherine Gabelleri
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): April 1st 1888
8. AGE: Years 59 Months Days If less than one day hrs. min.
9. Birthplace (Town, county, and state): Riparbella, Province of Pisa, Italy
10. Usual occupation: Butcher
11. Industry or business: Restaurant
FATHER 12. Name: Ralph Gabelleri
13. Birthplace: Italy
MOTHER 14. Maiden name: Caroline Gamburini
15. Birthplace: Italy
16. Informant: Catherine Gabelleri
Address: 41 Bradford St. Providence R. I.
17. Shipped (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: John Di Iorio & Sons
Location: 189 Atwells Ave. Providence, R. I.
18. Funeral director: Francis Gasch's Sons
Address: Hyattsville, Md
19. 4/12 47 (Date rec'd by registrar) Amanda Dawney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1947, at 6:45 A
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy Medical Examiner
23. SIGNATURE: [illegible] M. D. or other
Address: Forestville Md Date signed: 4-11-47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01269

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: PRINCE GEORGES
City or town: LAUREL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 YEARS
Hospital, Institution, or street address where death occurred:
385 MAIN STREET
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: PRINCE GEORGES
City or town: LAUREL
(If outside city or town limits, write RURAL and give nearest town)
Street No. 385 MAIN STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ANNA PANARETOS GAVRILES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife: SPEROS GAVRILES
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JAN. 8, 1871

8. AGE: Years: 76 | Months: 3 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: GREECE (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business

FATHER
12. Name: PETE PANARETOS
13. Birthplace: GREECE

MOTHER
14. Maiden name: —
15. Birthplace: GREECE

16. Informant: CHRISTINA GAVRILES
Address: 385 MAIN ST., LAUREL, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 4-14-47 (month) (day) (year)
Cemetery or crematory: WOODLAWN CEMETERY
Location: BALTIMORE, Md.

18. Funeral director: Arthur L. Talley
Address: 505 Washington Blvd. Laurel Md.

19. April 11 1947 (Date rec'd by registrar) Cora E. Wootten Registrar
Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 10, 1947, at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7 6 1946 to 4 10 1947 and that I last saw her alive on 4 10 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION: 1 d

Due to: Hypertension Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. Warren M. D. or other

Address: Laurel Md. Date signed 4-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (A5-2)

CERTIFICATE OF DEATH

JB 11252

Reg. Dist. No. 231

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

I

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Prince George Gen. Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ... County: ...
City or town: DISTRICT OF COLUMBIA.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3914-21ST STR. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ... ✓

3.(a) FULL NAME: TIMOTHY A. GERAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: HAZEL O. GERAN
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): MARCH - 1 - 1894

8. AGE: Years	Months	Days	If less than one day
53	1	17	...hrs. ...min.

9. Birthplace: HOLYOKE MASS.
(Town, county, and state)
10. Usual occupation: PRESSMAN
11. Industry or business: BUREAU OF ENGRAVING

FATHER
12. Name: EUGENE GERAN
13. Birthplace: IRELAND

MOTHER
14. Maiden name: MARY CURRAN
15. Birthplace: IRELAND

16. Informant: HAZEL O GERAN
Address: 3914 - 21ST STR. N.E. WASH. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4 - 18 - 47 (month) (day) (year)
Cemetery or crematory: St Jeromes Cemetery
Location: Holyoke, Mass
18. Funeral director: H. H. Chambers Co.
Address: 517 - 11th St. S.E.
19. 4/17 19 47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 17 19 47 at 10 20 A.M. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cerebral Compression,	
Due to Intra Cranial hemorrhage	
Due to Fracture of skull	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: unknown Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other
Address: Fredericksburg Va. Date signed 4-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01270

Reg. Dist. No. 231

M

I

T

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4412 Oliver Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Gover, Edward Murray

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Male	White	Married

6.(b) Name of husband or wife: Flora L. Gover
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 28, 1887

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Friendship, Md.
(Town, county, and state)
10. Usual occupation: Mayor of Hyattsville, Md.
11. Industry or business

FATHER
12. Name: Edwin Gover
13. Birthplace: Md.

MOTHER
14. Maiden name: unknown
15. Birthplace: Md

16. Informant: Flora L. Gover
Address: Hyattsville Md.

17. Burial — Date thereof April 12, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Friendship Cemetery
Location: Friendship Md
18. Funeral director: F Rastle Long
Address: Hyattsville Md.

19. 4/11/1947 Amanda Downes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 6.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-15- 1946 to 4-10 1947
and that I last saw h. l.m. alive on 4-10-47 19

Immediate cause of death	DURATION
a. Coronary occlusion	1 hr.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John P. Clum M.D.
M. D. or other
Address Hyattsville Md Date signed 4-10-47

RECEIVED
APR 14 1947
BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BFa)

CERTIFICATE OF DEATH

01271

Reg. Diat. No. 232

1. PLACE OF DEATH:

County: Prince Georges

City or town: Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, Institution, or street address where death occurred: Allentown Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Allentown Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Andrew Gray

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Bessie Gray

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 1887

8. AGE: Years: 60 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Llewellyn Gray

13. Birthplace: Maryland

MOTHER 14. Maiden name: Eliza Hawkins

15. Birthplace: Maryland

16. Informant: Bessie Gray

Address: Camp Springs Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 11, 1947 (month) (day) (year)

Cemetery or ~~crematory~~: St. Thomas Methodist Episcopal Church yard

Location: Aquasco Md

18. Funeral director: Eugene Ford

Address: 913 - 4½ St. S.W. Wash. D.C.

19. April 8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1947, at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary thrombosis heart failure	
Due to: Cardiovascular renal disease	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner Eugene Ford M. D. or other

Address: Forestville Md Date signed: 5-8-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

01272

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 4 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 month, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2917 Olive Place, N. W. Georgetown
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES WILLIAM GREEN

3.(b) Social Security Number: 229-26-7582

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22, 1890

8. AGE: Years	Months	Days	If less than one day
56	9	3	hrs. min.

9. Birthplace: King George Co., Virginia
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: Peter Pan Restaurant

FATHER
12. Name: C. C. Green
13. Birthplace: Stafford, Virginia

MOTHER
14. Maiden name: Georganna Morgan
15. Birthplace: King George Co., Virginia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29-1947 (month) (day) (year)

Cemetery or crematory: Mt. Zion Church Cemetery

Location: Montgomery Co. Maryland

18. Funeral director: F. H. Chamberlain Co

Address: Wash, DC 3072-M St. N.W.

19. 4-26-1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 25 1947, at 1:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 20 1947 to APRIL 25 1947 and that I last saw h[illegible] alive on APRIL 25 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	6 mo
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 4/25/47

M

1

T

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for he addition of year of birth and change of age is shown on G 109 4/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01273

Reg. Dist. No. 245

1. PLACE OF DEATH:
County PRINCE GEORGES
City or town NEAR College PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 MONTHS
Hospital, institution, or street address where death occurred:
Mother JONES Rest Home
How long in hospital or institution? 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County Montgomery
City or town BROWNINGSVILLE, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME George A. HOUSEN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) — 1865

8. AGE: Years	Months	Days	If less than one day
82 84 1	11	23	..... hrs. ..... min.

9. Birthplace Myersville, Fred. Co., Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business —

FATHER
12. Name LOUIS HOUSEN
13. Birthplace GERMANY

MOTHER
14. Maiden name Hester Remsburg
15. Birthplace Myersville, Md.

16. Informant MRS. Molly Gladhill.
Address BROWNINGSVILLE, RFD. Monrovia

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof April 4, 1947 (mouth) (day) (year)
Cemetery or crematory Bethesda
Location Brownningsville, Md.

18. Funeral director I. B. Beall Ins.
Address DAMASCUS, Md.

19. April 2 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946 to ..... 19..... and that I last saw h.. alive on recently 19.....

Immediate cause of death	DURATION
Chronic myocarditis	Several years
Due to Senility	Several years
Due to Arteriosclerosis	Several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wm. Allen Griffith M. D. or other
Address Brunswick Md. Date signed 4/6/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-E

CERTIFICATE OF DEATH

(B) 01274

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 404 - 3rd St., S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FLORENCE B. JACKSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Harry F. Jackson
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): August 29, 1919

8. AGE: Years	Months	Days	If less than one day
27	7	26	...hrs. ...min.

9. Birthplace: Greenville, South Carolina (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: - - -

FATHER
12. Name: Frank Henderson
13. Birthplace: Greenville, South Carolina

MOTHER
14. Maiden name: Mamie Baten
15. Birthplace: Columbia, South Carolina

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 25, 1947 (month) (day) (year)
Cemetery or crematory
Location: Wash D C
18. Funeral director: John T. Rhines & Co.
Address 901 - 3rd St. S.W
19. Apr. 24, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 24 1947 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from APRIL 2 1947, to APRIL 24 1947
and that I last saw h. E R alive on APRIL 24 1947

Immediate cause of death: PULMONARY TUBERCULOSIS — DURATION: 5 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Md. Date signed: 4.24.47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

01275

Reg. Diat. No. 237

1. PLACE OF DEATH:

County: Prince Georges

City or town: Aquasco Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Prince Georges

City or town: Aquasco Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lucy Johnson

3.(b) Social Security Number:

4. Sex: F

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: James Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 4, 1902

8. AGE: Years: 45 Months: 1 Days: 24 If less than one day: ..... hrs. ..... min.

9. Birthplace: Aquasco Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: Thomas Fowler

13. Birthplace: Aquasco, Md.

MOTHER

14. Maiden name: Nancy Contee

15. Birthplace: Aquasco, Md.

16. Informant: Walter Fowler brother

Address: Baltimore, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-1-47 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: Aquasco Md

18. Funeral director: Hutchins & Gray

Address: Waldorf md

19. April 28th 1947 (Date rec'd by registrar) Mrs Henry B. Contee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1947, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1947 to April 28 1947

and that I last saw h...ex alive on April 20, 1947

	DURATION
Immediate cause of death: Cardiovascular (Circulatory) Collapse	
due to: Anoxia	
Due to: Carcinoma, left breast	
& anterior wall.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Elbert R. Lapen, M.D. M. D. or other

Address: Aquasco, Md Date signed April 28, 1947

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

01276

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State: Md. County: Prince George
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Patience Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Colored	Married

6.(b) Name of husband or wife: James C. Johnson
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1892

8. AGE: Years	Months	Days	If less than one day
55			hrs. min.

9. Birthplace: Savannah Ga.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: James Carter
13. Birthplace: Ga.

MOTHER
14. Maiden name: Mariah Lee
15. Birthplace: Ga.

16. Informant: Mr. Carl Solomon
Address: 1702 Vermont Ave. N.W. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 6 1947 (month) (day) (year)
Cemetery or crematory: Glenarden,
Location: Glenarden, Md.

18. Funeral director: J. B. Johnson
Address: Annapolis

19. April 3 1947 (Date rec'd by registrar) Mrs. J. W. Quigley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 3 1947, at 5.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~Dec~~ 3-23-47 1947, to 4-1-47 1947
and that I last saw h~~im~~er alive on 4-1-47 1947

Immediate cause of death	DURATION
Cardiac Failure	
Due to Hypertensive Cardio-vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: John B. Lyon, Jr. M.D. M. D. or other
Address: Bowie, Md. Date signed 4-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

01277

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Prince Georges Co.
City or town: Near Laurel Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Laurel Sanitarium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Hyde
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Lane

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sara Cardina Hockett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 19-1868

8. AGE: Years 79 | Months . | Days 17 | If less than one day: hrs. min.

9. Birthplace: Virginia (town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER — 12. Name: George Lane
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Jane Bailey
15. Birthplace: Va

16. Informant: George D. Lane
Address: Hyde Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof April 9-47 (month) (day) (year)

Cemetery or crematory: Oak M. E. Cem
Location: Oak Md.

18. Funeral director: Clarence E. Arthur
Address: Oak Md.

19. 4-7 1947 (Date rec'd by registrar) Cap E Wachter Deputy. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1947, at 8:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 1946, to April 6 1947 and that I last saw h.. alive on April 6 1947

Immediate cause of death: Generalized Arterio-Sclerosis — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jesse C Eggers M.D.
M. D. or other
Address: Laurel Md Date signed 4/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(94a) 01278

Reg. Diat. No. 245

VS A1 (1) (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince George
City or town Mt. Rainier Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George
City or town Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3824 - 34th St.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME ISIDOR M. LAVINE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Bessie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 20 - 1904

8. AGE: Years 42 | Months 10 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Syracuse N.Y. (Town, county, and state)
10. Usual occupation Physician
11. Industry or business

FATHER
12. Name Maurice
13. Birthplace Russia

MOTHER
14. Maiden name Lark
15. Birthplace Russia

16. Informant Lee. Harold H. Lavine
Address 1348. Fanaquit St. NW

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 7-1947 (month) (day) (year)
Cemetery or crematory Glenarden
Location Wash. D.C.

18. Funeral director Goldberg Funeral Home
Address 4717 - 9th St. N.W.

19. April 5 1947 (Date rec'd by registrar) James Leary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on- April 5 1947, to ..... 19..... and that I last saw h.. alive on April 5 1947

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wm H Norton M. D. or other
Address 3827 34th St Mt Rainier Md. Date signed 4-5-47

I saw the Isadore Lovins at 3:45 P.M. was having precordial pain (severe) gave him Morph. Sulph. gr ¼ - and Nitroglycerin 1/150. Pain subsided. patient was comfortable until about 6 55 P.M. had another attack and passed away at 7 P.M.

Consulted dr James Boyd + coroner J P.I. Gro. Co.

01280

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-a)

CERTIFICATE OF DEATH

SD MW Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Imminent

Hospital, institution or street address where death occurred: Melrose Crossing

How long in hospital or institution? 8

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Col. County:

City or town: ~~Hyatt~~ Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4817 - 43rd pl. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME Frank Pierce Leitch

3.(b) Social Security Number 579-20-1484

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Pauline Leitch

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): 4/7/1887

8. AGE: Years	Months	Days	If less than one day
60	0	12	...hrs. ...min.

9. Birthplace: Fredrisburg Va. (Town, county, and state)

10. Usual occupation: Interior Decorator.

11. Industry or business:

FATHER 12. Name: Frank P. Leitch

13. Birthplace: Va

MOTHER 14. Maiden name: Ann E. Berry

15. Birthplace: Va

16. Informant: Pauline Leitch (wife)

Address: Washington, dc

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr 19, 1947 (month) (day) (year)

Cemetery or crematory: Pine Funeral Home

Location: 14th & Harvard st N.W. Washington D.C.

18. Funeral director: F Goschie son

Address: Hyattsville Md.

19. April 19 1947 (Date rec'd by registrar) James Seay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1947 at 1140 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to: Crushed skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 4-19-47

Where did injury occur? Hyattsville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) R.R. Crossing

Means of injury: Train, car struck Injured at work? Train

Report to medical Examiner

23. SIGNATURE: ...M. D. (or other)

Address: Hyattsville Md. Date signed 4-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01279

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4103 Oliver st.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Dorothy C. Ludwig

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Jacob Ludwig
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Mar 13, 1914

8. AGE: Years: 33 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: John Carroll
13. Birthplace: Md.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Jacob Ludwig
Address: Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 11, 1947 (month) (day) (year)
Cemetery or crematory: Arlington Cemetery
Location: Arlington Va.

18. Funeral director: L. Gasch's Sons.
Address: Hyattsville Md.

19. April 11 1947 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8, 1947, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-9 1947, to 4-8 1947
and that I last saw her alive on 4-4 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	
Due to	
Due to	
Other conditions: Jaundice & Metastasis to Liver	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Hyattsville, Md. Date signed: 4-9-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (133-a)

CERTIFICATE OF DEATH

01281

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
Prince Geo. General Hosp.
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Kennybrook
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4119 56th ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Monahan, Mrs. Maude

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife: John Monahan
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 9-1-1881

8. AGE: Years	Months	Days	If less than one day
65-6			..... hrs. ..... min.

9. Birthplace: Lewiston Pa.
(Town, county, and state)
10. Usual occupation: H. W.
11. Industry or business:
FATHER 12. Name: Wm. McCann
13. Birthplace: Westminster, Md.
MOTHER 14. Maiden name: Miriam Harper
15. Birthplace: Belltown, Md.
16. Informant: John Monahan
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-8-47 (month) (day) (year)
Cemetery or crematory: St Lincolns
Location: Colmar Manor, Md.
18. Funeral director: H. H. Chambers Co.
Address: 5117 11th St N.E.
19. 4/5 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-5 1947, at 2 20 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 21 1947 to April 5 1947
and that I last saw h.. alive on April 4 1947

Immediate cause of death	DURATION
Acute Bronchopneumonia	
Cystitis - Pyonephritis & Pyonephrosis	10 days
Due to: Infection	
Due to:	
Other conditions: Dementia.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John J. Maloney M. D. or other
Address: Cheverly-Hyattsville Md. Date signed 4-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

S 01282

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos., 14 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1418 W. St., N. W., Apt #40
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RUTHENE MONTGOMERY

3.(b) Social Security Number: 578-28-1834

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Separated

6.(b) Name of husband or wife: James Montgomery

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 3, 1924

8. AGE: Years	Months	Days	If less than one day
22	6	11	..... hrs. ..... min.

9. Birthplace: Ashville, North Carolina
(Town, county, and state)

10. Usual occupation: Clerical Worker

11. Industry or business: Treasury Department

FATHER
12. Name: John Franklin
13. Birthplace: ? , South Carolina

MOTHER
14. Maiden name: Agnes Rice
15. Birthplace: ? , South Carolina

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr. 14 1947 (month) (day) (year)

Cemetery or crematory

Location: to Washington, D.C.

18. Funeral director: Hall Bros.

Address: 621 Fla. Ave N.W. Wash. D.C.

19. Apr. 14, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 14 1947 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 29 1946 to APRIL 14 1947 and that I last saw h.. S.R. alive on APRIL 14 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	8 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 4.14.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of age shown on :

01283

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (35)

Serial No. G 109 APR 29 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: P. Geo.
City or town: near Bowie Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: P. Geo.
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Richard Edgar Mullikin / Richard Edgar

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary Lloyd Mullikin
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Aug. 8 1889

8. AGE: Years	Months	Days	If less than one day
57 57	8	4	— hrs. — min.

9. Birthplace: Upper Marlboro Md (Town, county, and state)
10. Usual occupation: Laborer then Carpenter
11. Industry or business:
FATHER 12. Name: Richard H. Mullikin
FATHER 13. Birthplace: Upper Marlboro. Md
MOTHER 14. Maiden name: Bertha E. Moore
MOTHER 15. Birthplace: Forestville, Md
16. Informant: Mary L. Mullikin
Address: Bowie. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 16 47 (month) (day) (year)
Cemetery or crematory: Ascension
Location: Bowie Md
18. Funeral director: Martin Gladden Jones
Address: Bowie Md
19. (Date rec'd by registrar) April 16 1947 Mrs. J. W. Gladden Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1947, at 10:15 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 12 1947, to April 12 1947
and that I last saw h[illegible] alive on April 12 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertension	5 hrs
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: G. Carpenter Jr. M. D. or other
Address: Bowie Date signed: 4/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01284

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: West Virginia County:

City or town: Shady Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME John Nevins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 4, 1946

8. AGE: Years	Months	Days	If less than one day
1		8	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: J. F. Nevins

13. Birthplace: Celina, Texas

MOTHER — 14. Maiden name: Orpha Clayscoe

15. Birthplace: Logan County, W. Va.

16. Informant: J. F. Nevins

Address: Shady Spring West Va

17. Burial, (Burial, cremation, or removal. Which?) Date thereof: Apr 14, 1947 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Bladensburg Md.

18. Funeral director: F Gaskins Sons

Address: Hyattsville Md.

19. 4/14 1947 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1947, at 12 20A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Toxemia	
Due to: Acute Gastro enteritis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: University medical Examiner J. C. Ford M. D. or other

Address: Hyattsville Md. Date signed: 4-13-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01285

B

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 2 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 1month, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 404 8th St., S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frederick S. Newman

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: — —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 27, 1878

8. AGE: Years	Months	Days	If less than one day
68	11	12	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Misc. Articles

FATHER — 12. Name: Jacob Newman

13. Birthplace: ?

MOTHER — 14. Maiden name: Loky

15. Birthplace: ? Virginia

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Apr. 9, 1947 (month) (day) (year)

Cemetery or crematory

Location to Washington, D.C.

18. Funeral director: Francis Collins

Address 3821-14th St. N.W. Wash. D.C.

19. Apr. 9 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1947, at 10 47 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/6/47 1947, to 4/9 1947 and that I last saw him alive on 4/9 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 Mo-17 da
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Bilat Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address Glenn Dale, Md. Date signed Apr. 9 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01287

CERTIFICATE OF DEATH

Reg. Dist. No. 2420

1. PLACE OF DEATH:
County: PRINCE-GEORGE
City or town: BRADBURY HEIGHTS (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 MONTHS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: MD County: PRINCE GEORGE
City or town: BRADBURY HEIGHTS (If outside city or town limits, write RURAL and give nearest town)
Street No. 5710-T-ST (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: RUSSELL-BURTON-PHILLIPS JR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): OCT 17, 1946

8. AGE: Years | Months: 5 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: WASHINGTON-DC (Town, county, and state)

10. Usual occupation: NONE

11. Industry or business

FATHER
12. Name: RUSSELL-BURTON-PHILLIPS
13. Birthplace: SILVER-HILL-MD

MOTHER
14. Maiden name: MARILYN-MAYHUE
15. Birthplace: ALIQUIPPA-PA-

16. Informant: RUSSELL-BURTON-PHILLIPS
Address: 5710-T-ST-BRADBURY-HGTS

17. Burial (Burial, cremation, or removal. Which?) Date thereof: APR 5 47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md
18. Funeral director: L. L. Chambers & Co
Address: 577-11 St SE.

19. April 3 19 47 Carrie F. Campbell (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 2 19 47 at 10 20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 March 19 47 to Death 19
and that I last saw h~~im~~ alive on 2 APRIL 19 47

Immediate cause of death	DURATION
PNEUMONIA Virus TYPE	72 Hrs
Due to —	
Due to —	
Other conditions: Acute tracheo-BRONCHITIS	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Sidney W. Lowry M.D. M. D. or other
Address: 1503 Good Hope Rd SE Date signed: 3 APRIL 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-L)

01288

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs.
Hospital, Institution, or street address where death occurred:
624 57th Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 624 57th Ave Cap. Hts.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Louis R. Pratt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Fillie V. Pratt
6.(c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): 10 — 1893

8. AGE: Years: 54 Months: 06 Days: 25 If less than one day: hrs. min.

9. Birthplace: Atlanta Georgia (Town, county, and state)
10. Usual occupation: Yardmaster Wash Terminal RR
11. Industry or business:
12. FATHER — Name: Andrew Pratt
13. FATHER — Birthplace: Atlanta, Georgia
14. MOTHER — Maiden name: Emma A. Pratt
15. MOTHER — Birthplace:
16. Informant: Fillie V. Pratt
Address: 624 - 57th Ave Cap. Hts Md.
17. Burial (Burial, cremation, or removal — which) Date thereof: April 29 47 (month) (day) (year)
Cemetery or crematory: Woodlawn National Cemetery
Location: Suitland Md.
18. Funeral director: W. W. Chambers Co.
Address: 517 11th St. S.E.
19. April 26 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26th 1947, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6th 1946 to April 26 1947 and that I last saw him alive on April 25th 1947

Immediate cause of death	DURATION
General Weakness & Starvation	
Due to: Carcinoma of Tongue + Pharynx	3 mo.?
Due to: Embolism - Ascending aorta	hrs. 1 hours
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arthur N. Meloy M. D. or other
Address: 4400 Bowen Rd D.C. Date signed: 4-26-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01289

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-1

CERTIFICATE OF DEATH

B Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 658 Morton St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HERBERT PRICE

3.(b) Social Security Number: 235-01-6717

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Ida Price

6.(c) If alive, give age: approximately 57 years

7. Birth date of deceased (mo., day, yr.): April 19, 1891

8. AGE: Years	Months	Days	If less than one day
55 55	11	21	...hrs. ...min.

9. Birthplace: Dodge Co., Eastman, Georgia
(Town, county, and state)

10. Usual occupation: Bricklayer

11. Industry or business: - -

FATHER
12. Name: William Price
13. Birthplace: Alabama

MOTHER
14. Maiden name: Lucy Lamar
15. Birthplace: Georgia

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr. 12, 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: A Boyd

Address: 1338 - 20th St. N.W.

19. April 9, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9, 1947, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1947, to April 9 1947 and that I last saw him alive on April 9 1947

Immediate cause of death	DURATION
Malignant Growth of left lung	3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glen Dale, Md. Date signed: April 9 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

01230

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Pgs Geo
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Prince Geo. General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pgs Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3501 Kenilworth Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Flora Radtke

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Edward Radtke
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 28, 1875

8. AGE: Years: 72 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Frederick Roth
13. Birthplace: Germany

MOTHER
14. Maiden name: Wilhemina Maste
15. Birthplace: Germany

16. Informant: Mrs Lina Schuler
Address: 3503 Kenilworth Ave Hyattsville Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Apr 10, 1947 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Bladensburg Md
18. Funeral director: F Raedts sons
Address: Hyattsville Md

19. 4/9 1947 (Date rec'd by registrar) Amanda Devries Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/7 1947, at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-1 1947, to 4-7 1947 and that I last saw h.. alive on 4-7 1947

	DURATION
Immediate cause of death: Acute Heart failure	4-6-47
Due to: Arteriosclerotic Heart & kidneys diseased	
Due to: Pa Grippe	4-1-47
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Geo Wagner M.D. (M. D. or other)
Address: 217-38th Ave Date signed: 4/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46 P)

01291

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:
County: Prince George
City or town: Nottingham, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Nottingham, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Maria Rawlings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Walter E. Rawlings
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): June 30 - 1892

8. AGE:

Years	Months	Days	If less than one day
54	9	11	hrs. min.

9. Birthplace: Nottingham Md.
(Town, county, and state)
10. Usual occupation: At home
11. Industry or business
FATHER 12. Name: John F. Goldsmith
13. Birthplace: Nottingham Md.
MOTHER 14. Maiden name: Ada Williams
15. Birthplace: Prince Geo. Co. Md.
16. Informant: Walter E. Rawlings
Address: Nottingham, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 15-47 (month) (day) (year)
Cemetery or crematory: Emmanuel
Location: Woodland P. Gds. Co. Md.
18. Funeral director: Pitkin Brothers
Address: Upper Marlboro Md.
19. April 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1947 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946 to April 11 1947 and that I last saw h[illegible] alive on April 10 1947

Immediate cause of death	DURATION
Carcinoma of Liver with Metastasis to Lungs.	10 Months
Due to	
Due to	
Other conditions Arteriosclerosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James E. Sasscer M. D. or other
Address: Upper Marlboro, Md. Date signed: 4-11-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-C

CERTIFICATE OF DEATH

01292

B

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 7 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 7 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 810 - 5th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JEWEL D. REESE

3.(b) Social Security Number: 202-03-423

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 15, 1914

8. AGE: Years	Months	Days	If less than one day
32	10	11	hrs. min.

9. Birthplace: Atlanta, Georgia
(Town, county, and state)

10. Usual occupation: Sheet-metal worker

11. Industry or business: --

FATHER
12. Name: James H. Reese
13. Birthplace: Atlanta, Georgia

MOTHER
14. Maiden name: Bessie V. Drake
15. Birthplace: Atlanta, Georgia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 30, 1947 (month) (day) (year)

Cemetery or crematory: College Park Cemetery

Location: College Park, Ga. Fulton Co.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St. Baltimore, Md.

19. Apr. 26, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 26 1947, at 7:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 18 1946, to Apr. 26 1947

and that I last saw him alive on Apr. 26 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 4-26-47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1525

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-A)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County... Prince Georges

City or town... College City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, Institution, or street address where death occurred: 3709 - College Terrace

How long in hospital or Institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince George's

City or town... College City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3709 - College Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war...

3.(a) FULL NAME Dorothy Virginia Alexander Removsky

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Albert J. Removsky

6.(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.): December 29, 1912

8. AGE: Years	Months	Days	If less than one day
34			...hrs. ...min.

9. Birthplace: Missouri (Town, county, and state)

10. Usual occupation: Medical Technician

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace: Indiana

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Indiana

16. Informant: Albert J. Removsky

Address: 3709 College Terrace College City

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Apr. 23, 1947 (month) (day) (year)

Cemetery or crematory...

Location: Farmington, Utah

18. Funeral director: P. Gaschy Sons

Address: Hyattsville, Md.

19. 4/23 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1947, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Coronary sclerosis	
Due to...	
Other conditions...	

(Include pregnancy within 3 months of death)

Major findings of operation... Date of op...

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) ...

Means of injury... Injured at work?

23. SIGNATURE: Deputy medical Examiner James L. Boyd M. D. or coroner

Address: Forestville, Md. Date signed: 4-22-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01293

Reg. Dist. No. 2-15

1. PLACE OF DEATH:
County Prince George.
City or town Avondale Grove.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George.
City or town Avondale Grove.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2116 - Queen Chapel Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JOHN A RIDDLER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife MAUDE M. RIDDLER. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 1st 1875

8. AGE: Years	Months	Days	If less than one day
72	2	10	..... hrs. ..... min.

9. Birthplace Aberdeen - Scotland.
(Town, county, and state)
10. Usual occupation Stone Mason.
11. Industry or business

FATHER
12. Name JOHN RIDDLER
13. Birthplace SCOTLAND.

MOTHER
14. Maiden name CATHERINE CRITTON
15. Birthplace SCOTLAND.

16. Informant Mrs Pearl Doyle.
Address 2116 - Queen Chapel Road.

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 11th 1947 (month) (day) (year)
Cemetery or crematory F.
Location Washington D.C.

18. Funeral director J. F. Costello
Address 1722 N. Cap st. Wash. D.C.

19. April 11" 1947 (Date rec'd by registrar) Mc Jas Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947, at 8:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1940 to April 11 1947 and that I last saw him alive on April 11 1947

	DURATION
Immediate cause of death: Congestive Heart Failure	4 days.
Due to: Arteriosclerotic Heart	
Due to: Chronic Arteriosclerosis	14 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank L Dorsey M.D. M. D. or other
Address 1201 N Cap St. Date signed Apr 14/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

01294

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred:
824-5-9th ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 824-5-9th ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Alice E Shaw

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas A
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): November 15, 1898

8. AGE: Years	Months	Days	If less than one day
48			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Home - wife
11. Industry or business

FATHER
12. Name: Walter S King
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rena J Stidhams
15. Birthplace: Virginia

16. Informant: Thomas A Shaw
Address: 824-5-9th ave, Capitol Hgts Md

17. Burial (Burial, cremation, removal, which?) Date thereof April 25, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Maryland

18. Funeral director: Robert A Mattingly
Address: 131-11th St S.E. Wash D.C.

19. 4/23 1947 (Date rec'd by registrar) Thos S. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1947 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3 1946 to April 22 1947 and that I last saw h.. alive on April 22 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 days.
Due to: Hypertensive cardio-vascular renal disease	5 years.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Brannon M. D.
Address: Capitol Hgts, Md. Date signed 4/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-415 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

01295

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges.
City or town: Maryland Park.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years.
Hospital, Institution, or street address where death occurred:
104-65th Ave, Maryland Park, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges.
City or town: Maryland Park.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 104-65th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Frank Timothy Shine

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: Rebecca W. Shine
6.(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): April 27, 1882.

8. AGE: Years: 64 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Kirkwood, Missouri (Town, county, and state)
10. Usual occupation: Stationary Engineer
11. Industry or business: Oil Co.
12. Father — Name: Dionysius Shine
13. Father — Birthplace: ?
14. Mother — Maiden name: Mary Dwyer
15. Mother — Birthplace: ?
16. Informant: Wm. James Shine
Address: 5413 - Powhatan Rd, Riverdale Md.
17. (Burial, cremation, or removal. Which?) transportation Date thereof: Apr 19, 1947 (month) (day) (year)
Cemetery or crematory: Oak Grove Cemetery
Location: Portsmouth, Va.
18. Funeral director: F. Gaeche's Sons
Address: Hyattsville Md.
19. 4/18/1947 (Date rec'd by registrar) Amanda Deuney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17, 1947, at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15, 1946 to April 17, 1947.
and that I last saw h[illegible] alive on April 15, 1947.

Immediate cause of death	DURATION
Coronary occlusion	3 days.
Due to: Arteriosclerotic coronary heart disease with	11½ years.
Due to: generalized arteriosclerosis	
Other conditions: Diabetes Mellitus	11½ years.

(Include pregnancy within 8 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William Shine M. D. or other
Address: Capitol Hgts, Md. Date signed: 4/17/47.
(own)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

4/17/47. - Coroner notified. Permission given for signing certificate

Brannin, MD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01296

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George

City or town: Beverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Prince George General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3510 - Perry St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Marcella June Simpson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Married

6.(b) Name of husband or wife: Edgar D. Simpson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 12, 1925

8. AGE: Years: 21 Months: 10 Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: George Glorius

FATHER 13. Birthplace: Washington, D.C.

MOTHER 14. Maiden name: Mary Marcella Schofield

MOTHER 15. Birthplace: Frostburg, Maryland

16. Informant: Edgar D. Simpson

Address: 3510 - Perry St. Mt. Rainier

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/3/47 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: 3201 - Bladensburg Rd. N.E. Brentwood, Md.

18. Funeral director: Wm. J. Malley

Address: 3200 - Rhode Island Ave. Mt. Rainier, Md.

19. 5/2/1947 (Date rec'd by registrar) Amanda Tawney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1947 at 12:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31 1946 to April 30 1947 and that I last saw her alive on April 30 1947

	DURATION
Immediate cause of death: Myeloid Leukemia	3 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles C. Hageage M.D. M. D. or other

Address: Mt. Rainier, Md. Date signed: April 30, 1947

01297

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

CERTIFICATE OF DEATH

MV Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 hours
Hospital, institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution? 19 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Maryland Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5-65 Ft
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Ethel Mae Sorrell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William T. Sorrell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1895

8. AGE: Years: 51 Months: 10 Days: 19 If less than one day: hrs. min.

9. Birthplace: Flint, Michigan (Town, county, and state)

10. Usual occupation: nurse

11. Industry or business

FATHER
12. Name: Edward Hodges
13. Birthplace: Flint, Michigan

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: William T. Sorrell
Address: 5-65 Ft, Maryland Park, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 17, 1947 (month) (day) (year)

Cemetery or crematory: Washington National Cem.
Location: Suitland, Md.

18. Funeral director: H. K. Chambers Co.
Address: 517-11th St. S.E.

19. 4/17/47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1947 at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed chest fracture 7 right ribs and fibula compound Comminuted fracture R. thigh & leg	
Due to:	
Other conditions: fracture L. hip & leg	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 4-16-47
Where did injury occur? Columbia Manor Park (City or town) (County) Md (State)
Injured at home, farm, industry, public place (where?) Road #1
Means of injury: Pedestrian struck by car Injured at work? no

23. SIGNATURE: James Deputy medical Examiner M. D. or other
Address: Forestville, Md. Date signed 4-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01298

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-d

CERTIFICATE OF DEATH

Reg. Diat. No. 745

1. PLACE OF DEATH:
County Prince George
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3507-Taylor
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William F. Spurlin

3.(b) Social Security Number 578-05-6226

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Gertrude L. Spurlin
6.(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) April 1st 1908

8. AGE: Years	Months	Days	If less than one day
39			hrs. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER 12. Name Edward W Spurlin
13. Birthplace Illinois

MOTHER 14. Maiden name Effie Landretta
15. Birthplace Illinois

16. Informant Mr Violet L Vermeulen
Address 2409-Bunker Hill Rd N.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-9-1947 (month) (day) (year)
Cemetery or crematory Cathedral Cemetery
Location Scranton, Pa.

18. Funeral director Wm J. Dalby
Address 3200 R.I. Ave Mt. Rainier Md.

19. April 7th 1947 Mrs. Jan Severd Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 6:45 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 6 1947, to Apr. 6 1947
and that I last saw him alive on Apr. 6 1947

Immediate cause of death	DURATION
Primary Carcinoma of Lungs	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles C. Hagedage M. D. M. D. or other
Address Mt. Rainier, Md. Date signed Apr. 6, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01299

Reg. Dist. No. 24 5

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Suitland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 29 Randall Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Edwin Horace Stow

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	married

6.(b) Name of ~~husband~~ wife: Oline May Stow

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1882

8. AGE:

Years	Months	Days	If less than one day
65	1	22	..... hrs. ..... min.

9. Birthplace: Suitland Md.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Standard Oil Company

FATHER 12. Name: Henry Lemington Stow

FATHER 13. Birthplace: New York

MOTHER 14. Maiden name: Mary Jane Thompson

MOTHER 15. Birthplace: New York

16. Informant: Bro. sister.

Address: 1000 Jackson N.E. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 11-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland maryland

18. Funeral director: Thos. F. Murray Funeral Home

Address: 2007 Nichols ave S.E.

19. April 9 47 (Date rec'd by registrar) James Seney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1947, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 April 1947, to 8 April 1947 and that I last saw him alive on 8 April 1947

Immediate cause of death	DURATION
Acute Nephritis-Uremia	2 wks?
Due to: Pneumonia	2 wks?
Due to: Arterio Sclerotic, hypertensive heart deseased	years?
Other conditions: Asthma, Chronic.	entire life

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Sidney W. Seney M.D. M. D. or other

Address: 1503 Good Hope Rd S.E. Date signed: 4-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

01300

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Forestville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months
Hospital, institution, or street address where death occurred:
Pr. Geo. Co. Alms House
How long in hospital or institution? 10 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Ardmore Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Lorretta Strauss

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 8, 1883

8. AGE: Years 63 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER 12. Name William Strauss
13. Birthplace Germany

MOTHER 14. Maiden name Ernestine Schell
15. Birthplace Germany

16. Informant Mrs. Charles B. McLeod
Address Ardmore, Md.

17. Burial (Burial, cremation, or removal—Which?) Date thereof Apr 28. 1947 (month) (day) (year)

Cemetery or crematory Prospect Hill
Location Washington D.C.

18. Funeral director L. Gabelmans
Address Hyattsville Md.

19. 4/27 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1947, at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946, to Apr. 25 1947 and that I last saw h[illegible] alive on Apr 21 1947

Immediate cause of death	DURATION
Hypertensive heart disease	
Due to	
Due to	
Other conditions Chr. Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE John D. Maloney M. D. or other
Address Cheverly Md. Date signed 4-25-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01301

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Bowie (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? transient

Hospital, institution, or street address where death occurred: Race Track Grand Stand

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Pennsylvania County: Lawrence

City or town: New Castle (If outside city or town limits, write RURAL and give nearest town)

Street No. 28 North Beaver Street (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Iva Swards

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Charles Swards

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): February 6, 1889

8. AGE: Years: 58 Months: Days: If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own Home

FATHER 12. Name: William Taylor

FATHER 13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Mallie

MOTHER 15. Birthplace: Pennsylvania

16. Informant: Joseph J. McConnell

Address: 2833-27th St. N.E. Washington D.C.

17. (Burial, cremation, or removal. Which?) transportation Date thereof: Apr 4 1947 (month) (day) (year)

Cemetery or crematory: New Castle

Location: Penna

18. Funeral director: F. Gasche Sons

Address: 1st attendant Md

19. 4/4 1947 (Date rec'd by registrar) Amanda Deeney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1947, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy medical Examiner James D. Boyd M. D. or other

Address: Forestville Md Date signed: 4-3-47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01302

Reg. Diat. No. 289

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Pr. Geo Co
City or town Laurel - md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Weavers Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Pr. Geo. Co
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. Montgomery Rd. Box 86
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Emily C. Taylor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Joseph F. Taylor 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 24 - 1883

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace Richmond, Va
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Luther Johnson
13. Birthplace Va

MOTHER 14. Maiden name Augustine
15. Birthplace Va

16. Informant Joseph F Taylor
Address Berwyn md

17. Burial, cremation, or removal. Which?) Burial Date thereof 4-11-47 (month) (day) (year)
Cemetery or crematory Rock Creek Cemetery
Location Wash. D.C.

18. Funeral director W W Chamberlain Co
Address Riverdale - md.

19. (Date rec'd by registrar) April 8 1947 M. Buckheare Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 8 1947 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 3 1947, to 4 8 1947
and that I last saw h[illegible] alive on 4 8 1947

	DURATION
Immediate cause of death Uremia	
Cerebrovascular disease	5 wks
Due to Bronchopneumonia	5 wk
Due to Pyelonephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B Ware M. D. or other
Address Laurel Date signed 4-8-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01303

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 1 month, 23 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 yrs., 1 month, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1524 U. Street, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: EVELYN SYLVESTINE TAYLOR

3.(b) Social Security Number: 599-20-0437

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Richard Taylor
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): October 6, 1913

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
33	6	24		

9. Birthplace: Green Co., Virginia
(Town, county, and state)

10. Usual occupation: Elevator Operator

11. Industry or business: Hotel

FATHER
12. Name: Walter Williams
13. Birthplace: Green Co., Virginia

MOTHER
14. Maiden name: Estelle Smith
15. Birthplace: Green Co., Virginia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Apr. 30, 1947 (month) (day) (year)
Cemetery or crematory
Location: to Washington, D. C.
18. Funeral director: H. Ernest Jarvis Jr.
Address: 1432 York St. N. W.

19. Apr. 30, 1947 (Date rec'd by registrar) H. T. Rowland & S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 30 1947, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 6 1945, to APRIL 30 1947 and that I last saw h...CR...alive on APRIL 30 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	2 yrs 10 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 4/30/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01304

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

1. PLACE OF DEATH:

County Prince George

City or town Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Prince George General Hospital

How long in hospital or institution? 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince George

City or town Cheverly (If outside city or town limits, write RURAL and give nearest town)

Street No. 4270 Branch Ave S.E. to D.C. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Tenny

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 3 1888

8. AGE:

Years	Months	Days	If less than one day
59	2	9	..... hrs. ..... min.

9. Birthplace Washington, DC (town, county, and state)

10. Usual occupation House Wife

11. Industry or business AT HOME

FATHER 12. Name William Handy

13. Birthplace D.C.

MOTHER 14. Maiden name Mary Hughes

15. Birthplace

16. Informant John A Connell

Address 4270 - Branch Ave S.E. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-15-47 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Prince George Co. - Suitland Rd

18. Funeral director W. W. Chamberlain Co

Address Washington DC.

19. 4/12 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946, to Apr. 12 1947

and that I last saw h.er alive on 4/11/47 1947

	DURATION
Immediate cause of death: Cardiovascular Renal disease	
Due to	
Due to	
Other conditions: Hardening of the Arteries	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. A. Tenney, M.D. M. D. or other

Address Hyattsville, Md. Date signed 4-12-47

Evidence for the change of age is shown on

01305

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

CERTIFICATE OF DEATH

FILM No. G 1 1 C MAY 6 1947

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hours 15 minutes
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hillside
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 57th & O St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Charles Thompson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 15, 1871

8. AGE: Years	Months	Days	If less than one day
75	9 6		hrs. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Franklin Thompson
13. Birthplace: Md

MOTHER
14. Maiden name: Melvina Tippett
15. Birthplace: Md

16. Informant: Charles Thompson
Address: 57th and O St, Hillside Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-21-47 (month) (day) (year)

Cemetery or crematory: Wash. National
Location: Suitland, Md.

18. Funeral director: Robert A. Mattingly
Address: 131-11th St. S.E. Wash. D.C.

19. 4/18 19 47 (Date rec'd by registrar) Amanda Daunes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1947, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other
Address: Forestville Md Date signed 4-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-a)

CERTIFICATE OF DEATH

01306

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Colmar Manor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred: 3313-40th Place

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Colmar Manor

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3313-40th Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Edward Waddell Jr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 17, 1870

8. AGE: Years 77 | Months | Days | If less than one day ..... hrs. ..... min.

8. Birthplace: Middleburg, Va (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John Edward Waddell Sr.

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Mildred Grimes

15. Birthplace: Virginia

16. Informant: Mrs. Etta Rhodon

Address: 3313-40th Ave, Colmar Manor

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20, 1947 (month) (day) (year)

Cemetery or crematory: Mt. De Zion

Location: Middlesburg Virginia

18. Funeral director: F. Gaschio sons

Address: Hyattsville Md

19. 4/19 (Date rec'd by registrar) 1947 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1947 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Uremia	
Due to: Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy medical Examiner James J. Boyd M. D. or dist.

Address: Forestville Md Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (190)

CERTIFICATE OF DEATH

01307

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George's
City or town: Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, Institution, or street address where death occurred:
Eastern Branch of the Potomac
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: No fixed
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Julia May Wallace

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Everett Wallace
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 20, 1904

8. AGE: Years	Months	Days	If less than one day
43			hrs. min.

9. Birthplace: Churchville, Tenn.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Joseph Whittmore
13. Birthplace: Churchville, Tenn.

MOTHER
14. Maiden name: Mary Dykes
15. Birthplace: Churchville, Tenn.

16. Informant: Clarence A. Whittmore
Address: Churchville, Tenn

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 14. 1946 (month) (day) (year)
Cemetery or ~~crematory~~: Evergreen
Location: Bladensburg Md

18. Funeral director: F Gaudlin sons
Address: Hyattsville Md.

19. 4/14/47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1947, at 3:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Exposure to cold	
Due to Laying out partly clad and partly submerged in water during	
Due to the night	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of
Where did injury occur? Eastern Branch of Potomac (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Stream
Means of injury: Lay out in cold Injured at work? No

23. SIGNATURE: Deputy Medical Examiner James S. Ford M. D. or Other
Address: Forestville, Md. Date signed 4/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

01308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (151-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 141

1. PLACE OF DEATH:
County: Prince Georges
City or town: Oakland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Years
Hospital, Institution, or street address where death occurred:
6505 Oakwood Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Oakland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6505 - Oakwood Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Grace Ferrer Watkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edmond M. Watkins
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 8, 1884

8. AGE: Years: 62 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Brooklyn, N. Y.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Frank P. Foster
13. Birthplace: New York

MOTHER
14. Maiden name: Catherine Stears
15. Birthplace: New York

16. Informant: Edmond Emery
Address: 6505 Oakwood Lane

17. Burial (Burial, cremation, or removal? Which?) Date thereof: April 7/47 (month) (day) (year)
Cemetery or crematory: Laurelwood Mem. Pk.
Location: Laurelwood Md.

18. Funeral director: S. L. Chambers & Co
Address: 917-11 St. S.E.

19. April 7 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1947, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Deputy Medical Examiner
23. SIGNATURE: Edward J. Ford M. D. or Other
Address: Forestville Md. Date signed 4-4-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01309

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Rural Laurel Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years.
Hospital, institution, or street address where death occurred:
Resident Physician
How long in hospital or institution? Same Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Same as other side County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Sathton Am Bethered

3.(b) Social Security Number 218-07-8816

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 22 - 1867

8. AGE: Years 79 | Months 10 | Days 12 | If less than one day ____ hrs. ____ min.

9. Birthplace: Chestertown Maryland
(Town, county, and state)

10. Usual occupation: Physician

11. Industry or business: Sanitarium

FATHER
12. Name: John S. Bethered
13. Birthplace: Kent Co Md.

MOTHER
14. Maiden name: Charlotte Spencer
15. Birthplace: Kent Co Md

16. Informant: L. Bethered Barroll
Address: 100 St Paul Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5, 1947. (month) (day) (year)
Cemetery or crematory: Shrewsbury Church Cemetery
Location: Kent County, Md.

18. Funeral director: Geo Burr Dallas
Address: 505 Washington Blvd., Laurel, Md.

19. 4-4 1947 Chas E. Wyckoff Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3rd 1947 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1947 to April 3 1947 and that I last saw him alive on April 3 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	24 hours
Due to: Hypertension	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jesse C Goyons M.D. (M. D. or other)
Address: Laurel Md Date signed: 4/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-C

CERTIFICATE OF DEATH

01310 45
Reg. Diat. No.

1. PLACE OF DEATH:
County ~~Montgomery~~ Prince George
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years
Hospital, Institution, or street address where death occurred:
6505 Alleghany Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery P. George
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6505 Alleghany Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARIE ELIZABETH WHITEHEAD

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or ~~wife~~ Ray Marion Whitehead
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 23, 1901.

8. AGE: Years	Months	Days	If less than one day
45	4	5	..... hrs. ..... min.

9. Birthplace Atlantic City, New Jersey
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name John Baum
13. Birthplace Texas
MOTHER 14. Maiden name Mary E. Willey
15. Birthplace North England
16. Informant Calvin L. Whitehead
Address 627 Farragut St. NW Wash. D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1 1947 (month) (day) (year)
Cemetery or crematory Geo. Nash Memorial Com.
Location Hyattsville, Maryland, Rhode Island Road
18. Funeral director Arthur L. Fallers
Address 254 Carroll St. N.W. Takoma Park, D.C.
19. April 30 1947 (Date rec'd by registrar) James Severy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 28, 1947, at 5:10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Apr 28, 1947
and that I last saw her alive on Apr 28 1947

Immediate cause of death	DURATION
Parkinson's Syndrome	Years
Pneumonia	Months
Due to Bed Sore	Days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations 0
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. H. Holdsworth M.D.
Address 500 Underwood NW M. D. or other
Date signed 4/28/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.